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MEMORANDUM

TO: Legislative Oversight Committee Members
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
MH/DD/SAS Stakeholder Organizations

Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
NC Assoc. of County DSS Directors

FROM: Dr. Craig L. Gray
Steven Jordan *SS*

SUBJECT: Implementation Update #87 - REVISED
Clarification of Unmanaged Outpatient Visits
Provisionally Licensed Billing Extension/NCCI
NCCI Update: Billing "Incident To"
Requests for Non-Covered Services: ADATC
Frequently Asked CABHA Billing Questions
New CABHA Provider Affiliation Denial Code

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Peer Support Service Update
Protocol for Out of State Placement/Enrollment
NC-TOPPS Enhancements
MH/SA & DD TCM Medicaid Audit Findings

Clarification of Unmanaged Outpatient Behavioral Health Visits

As clarified in the March 2011 Medicaid Bulletin and Implementation Update #86, beginning January 1, 2011, children under the age of 21 have 16 unmanaged outpatient visits before prior authorization is required. Adults (21 years and older) have 8 unmanaged outpatient visits before prior authorization is required. This visit count begins each calendar year and runs from January-December. For recipients reaching their 21st birthday in a calendar year: these recipients still count as 'children' for unmanaged visit counts until the end of that calendar year; therefore the 16 unmanaged visit limit applies to that calendar year. Beginning January 1 of the next calendar year, the 8 adult unmanaged visit limit will apply. Providers are responsible for recognizing when prior approval is required. While prior approval may not be required until later in each calendar year, it is prudent to seek prior approval as early as possible to ensure payment. Please refer to the March 2011 Medicaid Bulletin which explains the calculation of unmanaged visits.

Extension of Coverage for Provisionally Licensed Providers Billing Outpatient Behavioral Health Services through the Local Management Entity and National Correct Coding Initiative Update

The coverage of provisionally licensed providers delivering outpatient behavioral health services as a reimbursable service under Medicaid funds and billed through the Local Management Entity (LME) has been extended to June 30, 2012. The HCPCS procedure codes that may be utilized to bill for services delivered by the provisionally licensed individuals billing through the LME are: H0001, H0004, H0005, and H0031. Provisionally licensed professionals billing HCPCS codes should use generally accepted guidelines for timeframes for individual outpatient sessions (generally 45-60 minutes) and group outpatient sessions (generally 90 minutes). Overuse of HCPCS code billing is being monitored by the Division of Medical Assistance (DMA) Program Integrity (PI) as part of federal Medicaid fraud initiatives. Providers should also review the March 2011 Medicaid Bulletin for guidance on counting unmanaged visits and requesting prior authorization.

DMA effectively implemented the federally-mandated National Correct Coding Initiative (NCCI) edits on March 31, 2011. Procedure-to-procedure editing (CCI) identifies procedures and services performed by the same provider on the same date of service for the same recipient. Provisionally licensed professionals billing through the LME, use the LME's national provider identifier (NPI) number. If multiple provisionally licensed professionals provide individual, family, or group therapy to the same recipient on the same date of service the second code billed will deny because the same attending NPI is billed for both services. As always, documentation in the record should clearly indicate who provided the service.

Providers are strongly encouraged to review the DMA NCCI webpage at <http://www.ncdhhs.gov/dma/provider/ncci.htm> and the Centers for Medicare and Medicaid Services (CMS) NCCI webpage at <http://www.cms.gov/MedicaidNCCICoding/> for further information and to confirm which procedure code pair combinations are allowable.

National Correct Coding Initiative Update: Provisionally Licensed Professionals Billing 'Incident To' the Physician

This article is intended to further clarify the April 2011 Medicaid Bulletin and Implementation Update #86 article regarding the NCCI for Outpatient Behavioral Health Providers. DMA effectively implemented the federally-mandated NCCI edits on March 31, 2011. Procedure-to-procedure editing (CCI) identifies procedures and services performed by the same provider on the same date of service for the same recipient. Provisionally licensed professionals billing 'incident to' the physician, use the physician's NPI number. If the physician were to provide medication management (i.e. 90862) and the provisionally licensed professional were to provide individual, family, or group, therapy on the same date of service, the second code would deny because the same attending NPI is billed for both services.

There are certain services/codes that provisionally licensed professionals will be able to provide on the same date of service that a physician provides medication management. When billing the service/code rendered by the provisionally licensed professional, the NCCI modifier 59 should be appended to CPT codes 90801, 90802, 90846, 99408, or 99409. The SC modifier should also be used (as it is used currently) to indicate that the service was rendered by a provisionally licensed professional billing 'incident to.' The use of these modifiers will allow the system to recognize that the service was provided by a different attending provider. The other CPT codes (90804, 90806, 90847, and 90853) that provisionally licensed professionals bill 'incident to,' cannot be overridden by appending modifiers, per federal guidelines. These codes can continue to be billed 'incident to' but will need to be provided on a separate date of service to be considered for reimbursement. Alternatively, for individual therapy codes 90804 and 90806, if medication management is provided on the same date of service, one code (90805 or 90807) can be billed to indicate that medication management and individual therapy were rendered. The SC modifier should be used when billing the combined codes. As always, documentation in the record should clearly indicate who provided the service.

Providers are strongly encouraged to review the DMA NCCI webpage at <http://www.ncdhhs.gov/dma/provider/ncci.htm> and the CMS NCCI webpage at <http://www.cms.gov/MedicaidNCCICoding/> for further information and to confirm that code pair combinations are allowable.

Requests for Non-Covered Services: Alcohol and Drug Abuse Treatment Centers

As of May 1, 2011, all requests for Alcohol and Drug Abuse Treatment Centers (ADATC) for consumers ages 18-21 will be reviewed as “non covered services requests” by Eastpointe LME, a Medicaid utilization review (UR) vendor. All new requests should follow guidelines for requesting approval found at:

<http://www.ncdhhs.gov/dma/epsdt/>. Providers should fill out the form on the website:

<http://www.ncdhhs.gov/dma/Forms/NonCoveredServicesRequest.pdf>. Providers should not submit in-patient treatment reports (ITRs) or person centered plans (PCPs).

All requests should be sent to:

Eastpointe LME
Eastpointe
ATTN: Anna North
PO Box 369
Beulaville, NC 28518
Fax: 910-298-7189

Note: A recipient under the age of 21 may receive a medically necessary service not included in the North Carolina Medicaid State Plan **only** when the service may be covered under federal Medicaid law and when it will “correct or ameliorate” a diagnosed condition in accordance with Federal Medicaid law at 42 U.S.C. § 1396d(a) and (r) of the Social Security Act.

Frequently Asked Critical Access Behavioral Health Agency Billing Questions

The following questions are those Critical Access Behavioral Health Agency (CABHA) billing questions frequently received at HP Enterprise Services and at DMA. These answers can be found in the Department of Health and Human Services (DHHS) Implementation Update (IU) #73, the September 2010 Medicaid Bulletin, the DMA CABHA webpage found at <http://www.ncdhhs.gov/dma/services/cabha.htm> and the training packet from the Fall 2010 CABHA Enrollment, Authorization, and Billing Seminars found at <http://www.ncdhhs.gov/dma/cabha/CABHAPresentation092010.pdf>. They have been provided here again in an effort to consolidate the information.

Q1: How do providers bill for Dates of Service prior to becoming a CABHA?

A1: The effective date of the CABHA is extremely important. If billing for Dates of Service prior to the effective date of the CABHA, claims should be billed with the Enhanced Mental Health Services NPI. In other words, they should be billed as they were billed prior to becoming a CABHA. If billing for Dates of Service *on* the effective date of the CABHA and Dates of Service moving forward, claims should be billed with the CABHA NPI as the billing number. If claims are billed under the CABHA NPI for Dates of Service prior to the effective date of the CABHA, the claim will deny for "Provider not effective or eligible on Date of Service." If at enrollment a provider chose NOT to subpart and get a separate NPI for their CABHA, the CABHA NPI and the Enhanced Mental Health Services NPI may be the same. In that instance, providers would bill with the Enhanced NPI and the mapping solution would choose the Enhanced NPI based off of the effective date.

Q2: How do providers bill for Mental Health/Substance Abuse Targeted Case Management (MH/SA TCM) under the CABHA?

A2: This can differ based on how the provider chose to link these services at enrollment. If at enrollment they chose to subpart (meaning they obtained a separate NPI for their CABHA MPN), the MH/SA TCM MPN will be linked to the CABHA NPI. If this is the case, they would simply report the NPI that is associated with the CABHA twice, meaning at both the Billing and Attending levels. If at enrollment the provider chose NOT to subpart and CABHA, Enhanced/Core Services, and MH/SA TCM are all linked to the same NPI, they would once again list that NPI at both the Billing and Attending levels and the mapping solution would select the correct MPN based on the service billed. In the event a provider obtained a separate NPI for MH/SA TCM, then the CABHA NPI will be placed at the Billing level and the NPI associated with MH/SA TCM will be placed at

the Attending level. The MH/SA TCM NPI will NEVER be placed at the Billing level, if placed at the Billing level, the claim will deny. Please see Clinical Coverage Policy on limitations of billing for MH/SA TCM services. *See Medicaid Bulletin September 2010.

Q3: Where should providers list their CABHA NPI on the claim, at the Billing level or the Attending level?

A3: The CABHA NPI will ALWAYS be at the Billing level. If the CABHA NPI is placed at the Attending Level, the claim will deny.

Q4: What claim form should providers use to bill for their CABHA? What should they put on the claim?

A4: Claims for all core and enhanced mental health CABHA services will be billed using the professional claim (CMS-1500/837P) format. The CABHA NPI should be listed as the "Billing Provider." The NPI associated with the individual provider (for comprehensive clinical assessments, outpatient therapy, and medication management) or the enhanced service (i.e. Intensive In Home, MH/SA TCM, etc.) for which Prior Authorization was obtained, should be listed as the "Attending Provider Number."

Claims for Residential Levels II-Program Type, III, and IV (provided by CABHAs) should continue to be billed using the Institutional Claim (UB-04/837I) format. In these instances, providers must continue to submit claims with the current billing NPI associated with the Level II-Program Type, III, or IV. In other words, providers should continue to submit claims for Levels II-Program Type, III, and IV services in the same way as they did prior to CABHA. IF PROVIDERS SUBMIT RCC CLAIMS UNDER THE CABHA NPI, THE CLAIM WILL BE DENIED.

Claims for Therapeutic Foster Care Level II-Family Type (provided by CABHAs) must continue to be submitted through the LME for processing. IF PROVIDERS SUBMIT THESE CLAIMS UNDER THE CABHA NPI, THE CLAIM WILL BE DENIED.

Q5: If a provider has multiple locations, how can they easily distinguish which location performed the service when all claims and reimbursement are returned on the Remittance and Status Report (RA) under the CABHA NPI?

A5: To determine the site where the service was performed, providers can include site identifying information within the Patient Account Number submitted on the claim. If billing on the 837P, the Patient Account Number is located within Loop 2300 Segment CLM01. If billing on the NCECSWeb Tool, this information is entered in the field titled Patient Account Number. The Patient Account Number cannot exceed 20 characters. This number will be returned on the RA allowing providers to distinguish which site performed the service for a particular claim.

New Critical Access Behavioral Health Agency Provider Affiliation Denial Code

DMA in collaboration with the CSC EVC Call Center conducted provider outreach to all CABHA providers to verify that the provider enrollment information on file with N.C. Medicaid is accurately linked to your CABHA billing provider number. **To ensure that claims adjudicate correctly, it is important to verify that attending provider(s) and service affiliation information has been correctly linked to your CABHA billing provider number.** Providers that have not responded to the email notification should immediately contact the CSC EVC Call Center at 1-866-844-1113.

Any attending provider (individual or service) not linked to the CABHA billing provider number that is billed through the CABHA billing provider will result in claim denials. A new EOB 1791, "The attending provider is not associated with the CABHA billing provider for the dates of service billed," was created. Providers that receive this EOB on their RA should contact the CSC EVC Call Center to correct their attending provider(s) and service affiliation information prior to resubmitting their claim.

Changes in Medicaid Prior Approval and Recipient Due Process (Appeal Rights) Policies and Procedures

The Division of Medical Assistance adopted new prior approval and recipient due process (appeal) policies and procedures effective May 27, 2011; the specific details are noted in the May 2011 Special Bulletin located at: <http://ncdhhs.gov/dma/bulletin/DueProcessSpecialBulletin5311.pdf>.

Training is planned for June 2011. Seminars are intended to address changes in Medicaid's prior approval policies and procedures and the Medicaid **recipient** appeal process when a Medicaid service is denied, reduced, terminated, or suspended. The seminar will also focus on an overview of Early Periodic Screening, Diagnosis, and Treatment (EPSDT)-Medicaid for Children.

The seminars are scheduled at the locations listed below. Sessions will begin at 9:00 a.m. and will end at 4:00 p.m. Providers are encouraged to arrive by 8:45 a.m. to complete registration. Lunch will not be provided at the seminars. **Because meeting room temperatures vary, dressing in layers is strongly advised.** Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

Providers and LMEs may register for the Changes in Medicaid Prior Approval Policies and Procedures, Recipient Due Process, and [EPSDT seminars online](#) or [by fax](#). **Pre-registration is required.** Providers will receive a registration confirmation specifying the training material(s) each provider should bring to the seminar.

Date	Location
June 7, 2011	Morganton Western Piedmont Community College-Moore Building 1001 Burkemont Avenue Morganton, NC 28655 get directions
June 14, 2011	Wilmington Hampton Inn – Medical Park 2320 South 17th Street Wilmington NC 28401 get directions
June 22, 2011	Raleigh The Royal Banquet and Convention Center 3801 Hillsborough Street Raleigh, NC 27607 get directions

Training slides may be found on DMA's website at <http://www.ncdhhs.gov/dma/provider/epsdthealthcheck.htm>.

DMA will offer three additional training sessions in Raleigh late this summer or early fall if there is adequate registration. Future Medicaid Bulletins will provide registration information. Resource information is available for review as indicated below and located on the DMA web site at <http://ncdhhs.gov/dma/provider/priorapproval.htm>.

- Medicaid Recipient Due Process Rights and Prior Approval Policies and Procedures
- Due Process and Prior Approval Procedures Special Bulletin, May 2011
- Medicaid Recipient Due Process and Prior Approval Policies and Procedures Seminar Presentation January 2011

For more information, please contact the DMA Behavioral Health Unit at 919-855-4290.

Peer Support Service Update

Peer Support is a very effective support service for individuals with mental health and substance abuse challenges. It is a highly valued service by consumers and families and they have been actively engaged in promoting this as a Medicaid reimbursed service.

A service definition was developed, to be provided only by CABHAs, and approved by CMS. Implementation was scheduled for July 1, 2011. Since the approval of the definition there have been numerous concerns raised, especially that the definition itself does not reflect true peer support and is too embedded in the medical model. Rate setting resulted in a rate that providers have indicated will result in substantial losses and they do not intend to offer the service. This feedback comes from providers who are fully supportive of peer support, train peer support specialists, and currently hire peer support specialists to work on team services such as Assertive Community Treatment Team (ACTT). This has led to the general sentiment in the provider and advocate community that this service will not be successful when implemented.

Peer support can be offered as a (b)(3) service within the 1915 (b)(c) waiver. PBH has offered a very successful peer support program that is generally perceived as being more “true” to peer support than the definition approved by CMS. The Department is committed to supporting peer support and to ensure its success and viability. To achieve this goal and in response to the concerns raised by stakeholders, the peer support service definition previously approved by CMS will not be implemented July 1, 2011 as planned. Peer support will be offered through the 1915 (b)(c) waiver sites.

In the interim, LMEs are strongly encouraged to utilize the already approved alternative service definition for peer support utilizing state funds (YA 308 Peer Support Individual, YA 309 Peer Support Group, YA343 Peer Support Hospital Discharge and Diversion). Each of these three alternative service definitions have been opened to allow all LMEs to bill these services. Peer Support Specialists may continue to provide services as team members under Community Support Team and Assertive Community Treatment Team.

We are grateful for the input from advocates, consumers, and providers and believe this response will meet the concerns about the definition and provide the necessary support to offer the service successfully.

Compliance Verification Protocol for Out-of-State Placement/Enrollment of Residential Services

Recent events have brought into question the lack of awareness of the out of state placement utilization review process. It is important that if adequate services cannot be accessed within the state, that the systems involved work in strong partnership to ensure appropriate placement and on-going monitoring. LMEs are critical to this process as they have access to paid claims and authorization data for the purpose of tracking the services consumers within their catchment area are receiving. In addition, two Implementation Updates (42 and 43) reference LME contact persons with UR agencies (ValueOptions, Durham or Eastpointe) and the need for the LME Director and Community Collaborative involvement in all out of state placements.

Implementation Update #43

It is the intent of the service system to develop and provide medically necessary services and supports for children and youth with serious behavioral health needs and their families in their home community. However, in a few instances, this may not be possible. In these cases, a compliance verification protocol must be completed for a specific child or youth with serious behavioral health treatment needs that meet medical necessity and for whom all clinically appropriate services and in-state resources have been explored and tried without improved outcomes as outlined in the person centered plan.

This compliance verification protocol and Out of State Packet can be obtained by calling ValueOptions at 1-888-510-1150 extension 292466, The Durham Center at 919-560-7244, or Eastpointe LME at 800-513-4002 #2. Out of state packet forms can also be found at: <http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/forms/forms-outofstplacement.pdf> and questions concerning the forms/process can be directed to DMA Behavioral Health Section at 919-855-4290.

The protocol includes the following components:

- Out-of-State (OOS) Placement Request Checklist
- Placement Request Guideline Form
- Out of State Acknowledgement/Support

All three of these documents must be followed and fully completed to be accepted before any consideration will be given to the request. Supporting documentation must be attached to the completed and signed request including:

- Service request (ITR)
- Certificate of Need for PRTF level of care
- Person centered plan
- Current comprehensive clinical assessment
- Treatment summaries
- Documentation of all in-state services and supports accessed
- Denial letters from all in state facilities with programming appropriate for recipient needs
- All other items as noted in the protocol checklist and guideline form

In addition, a Child and Family Team representative, the LME Director and the Community Collaborative must be part of this planning and decision-making process for such a referral to be made. The LME Director and the chair of the Community Collaborative must sign the Out of State placement acknowledgement/support statement agreeing with the referral and assuring compliance with all policies and procedures have been followed and all in-state resources have been exhausted. The request will not be considered complete without all required components and supporting documentation. Upon submission of the completed request to ValueOptions, The Durham Center, or Eastpointe LME the review process will begin and authorization determination made within five business days for enrolled providers. The compliance review of out of state providers is a joint process between DMA and DMH/DD/SAS. Steps for out of state providers include the following:

- UR vendor contacts DMA, Behavioral Health Section, when the decision has been made to approve (or deny) out of state placement for a Medicaid recipient.
- If DMA supports approval, the agency contacts the Accountability Section of DMH/DD/SAS to conduct a compliance review of the facility.
- Once the compliance review is completed, DMA is notified of the findings.
- DMA Behavioral Health Section reviews the findings of the compliance review, contacts the Medicaid Agency in the home state of the provider and makes the final decision regarding meeting the standards and qualifications for enrollment.
- Once compliance is determined, the provider is notified of their ability to enroll with Medicaid.
- DMA Rate Setting will establish a rate and DMA Provider Services will enroll the provider upon completion and receipt of an approved application.
- The UR vendor is notified of the findings and to proceed with the process of entering the prior authorization for appropriate payment.

As a reminder Implementation Update #42 also specified that each LME has identified a liaison to network with the UR vendor regarding all out of state placements, complex cases such as those with multiple diagnoses, and cases involved with juvenile justice.

NC-TOPPS Enhancements:

Effective July 2011, providers who submit consumer outcomes information to NC-TOPPS will notice a more user-friendly and streamlined design. Please be watching for more information to come later this month on a user test site which will give providers an opportunity to familiarize themselves with the new design. The overall goal of the redesigned system was to make it more functional and efficient for users.

In addition, we are pleased to announce new enhancements to the “Outcomes at a Glance 2.0” online dashboard, including more user choices for time period selection and improvements to methodology, which increases data available for provider agencies. You can access the dashboard by going to the NC-TOPPS homepage at: <http://www.ncdhhs.gov/mhddsas/nc-topps/> and clicking on the icon “NC-TOPPS Outcomes at a Glance 2.0.”

Input and feedback from stakeholders has been very helpful in the continual improvements to NC-TOPPS. We appreciate this collaborative effort and continue to seek your suggestions for improving our consumer outcomes system. If you have questions regarding NC-TOPPS or the dashboard, please send them via electronic mail to: ContactDMHQuality@dhhs.nc.gov.

MH/SA and IDD Targeted Case Management Audits: Positive Trends and Area of Concern

The Division of Medical Assistance and the Division of Mental Health/Developmental Disabilities and Substance Abuse Services recently completed an audit of Targeted Case Management (TCM) services. These audits were conducted from March 1, 2011 through March 31, 2011 for services delivered between the dates of November 1, 2010 and January 31, 2011. Results of these audits indicate positive improvements in the delivery of services but also point out continuing areas of concern. Following are a summary of these findings:

Mental Health and Substance Abuse TCM

Positive Trends and Findings

- Service authorizations from the Medicaid vendors are in place for MH/SA TCM.
- Service plans are in place and valid, meaning they have the appropriate signatures, are reviewed as required and have the appropriate services indicated.
- Eligibility criteria for MH/SA TCM were met for people receiving the service.
- Providers requiring disclosure of criminal convictions by prospective employees prior to hire were in place.
- Health Care Personnel Registry checks prior to hire were in place.
- The majority of case managers met the education and experience requirements to provide the service.

Areas of Concern

Service Plan Signatures

There continue to be issues with Person Centered Plans being signed prior to the plan date and signatures not being dated by the signatory. Signatures must be on or after the plan date and a signature is validated only after the signatory enters the date of the signature.

Service Documentation

Review of the documentation of the delivery of services resulted in several areas of concern:

- The absence of a monthly face to face meeting with the person receiving services was the most prevalent issue.
- Content of service documentation that did not meet the requirements of the service definition. Some examples of this are:
 - Documentation indicating checking Medicaid eligibility status as the only intervention for the week of service.
 - Researching resources for potential future needs.
 - Calling to inform individuals of the Case Managers’ schedule or other issues not related to the individual.
 - Calling weekly to check on the individual’s status with no evidence of on-going issues or noted needs. This type of intervention appeared to be more for the purpose of the agency billing the service versus the need for the service by the individual.
 - Documentation of individual counseling.
- Excessive reviewing of the Person Centered Plans and other documentation without a clear need being evident.

Qualifications/Training

The main area of concern was the lack of training specifically required by the new service definition.

Intellectual/Developmental Disabilities (I/DD) TCM

Positive Trends and Findings

- Service authorizations are in place for I/DD TCM.
- Service plans are in place and valid, meaning they have the appropriate signatures, are reviewed as required and have the appropriate services indicated.
- Eligibility criteria for I/DD TCM was met for people receiving the service.
- Providers requiring disclosure of criminal convictions by prospective employees prior to hire were in place.
- Health Care Personnel Registry checks prior to hire were in place.
- The majority of case managers met the education and experience requirements to provide the service.

Areas of Concern

Service Plans

There continues to be issues with non CAP-MR/DD Person Centered Plans being signed prior to the plan date and signatures not being dated by the signatory.

Service Documentation

There was some concern of excessive monitoring and reviewing of the Person Centered Plans and other documentation without a clear need being evident.

Some provider's "electronic signatures" failed to meet the requirements as noted in the Records Management and Documentation Manual (APSM-42), specifically that the system did not prevent the entry from being deleted or altered.

Qualifications/Training

Lack of training as required by the State Plan Amendment and service definition was the major area of concern.

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@dhhs.nc.gov.

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